



ENSURING HEALTH SECURITY IN THE AFRICAN REGION

Emergency Preparedness and Response Activities



World Health Organization

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Acronyms

AAR	After Action Review
ADG	Assistant Director General
AFRO	The World Health Organization Regional Office for Africa
AIDS	Acquired Immunodeficiency Syndrome
AVoHC	African Health Volunteers Corps
AVoHC-SURGE	African Volunteers Health Corps-Strengthening and Utilizing Response Groups for Emergencies
CADRI	Capacity for Disaster Reduction Initiative
CAR	Central African Republic
CDC	Centers for Disease Control and Prevention
CFE	Contingency Fund for Emergencies
CFR	Case Fatality Rate
CONOP	Concept of Operation
COVID-19	Coronavirus Disease 2019
CSO	Civil Society Organization
CVDP2	Circulating Vaccine Derived Poliovirus type 2
DHIS2	District Health Information Software 2
DRC	Democratic Republic of the Congo
ECHO	Extension for Community Healthcare Outcomes
ECSA	East, Central and Southern Africa
ECSA HC	East, Central and Southern Africa Health Community
EIOS	Epidemic Intelligence from Open Sources
EOC	Emergency Operation Center
EOCNET	Emergency Operation Center Network
EPR	Emergency Preparedness and Response
EVD	Ebola Virus Disease

EYE	Eliminate Yellow Fever Epidemics
FAO	Food and Agriculture Organization of the United Nations
GBV	Gender-based Violence
GHoA	Greater Horn of Africa
HCW	Health Care Worker
HIR	Health Emergency Information and Risk Assessment Programme
HPIS	Health Programming and Information Services
ICAP	International Centre for AIDS Care and Treatment Program
IDSR	Integrated Disease Surveillance and Response
IEC	Information, Education and Communication
IEHK	Interagency Emergency Health Kits
IGAD	Intergovernmental Authority on Development
IHR	International Health Regulations
IINSP	Institut National de Santé Publique
IMS	Incident Management System
IMST	Incident Management Support Team
IPC	Infection Prevention and Control
JEE	Joint External Evaluations
MEF	Monitoring and Evaluation Framework
MHNT	Mobile Health and Nutrition Teams
MHPSS	Mental Health and Psychosocial Support
MOH	Ministry of Health
NAPHS	National Action Plan for Health Security
NBW	National Bridging Workshop

NFP	National Focal Person
NGO	Non-governmental Organization
OCV	Oral Cholera Vaccines
OSL	Operations Support and Logistics
PCR	Polymerase Chain Reaction
PHE	Public Health Event
PHEIC	Public Health Event of International Concern
PHEOC	Public Health Emergency Operations Centre
PHI	Public Health Intelligence
POE	Points of Entry
PPE	Personal Protective Equipment
PPP	Public Private Partnership
PROSE	Promoting Resilience of Systems for Emergencies
PRSEAH	Preventing and Responding to Sexual Exploitation, Abuse and Harassment
PVS	Performance of Veterinary Services
Q1	Quarter 1
Q2	Quarter 2
Q3	Quarter 3
Q4	Quarter 4
RCCE	Risk Communication and Community Engagement
RKI	Robert Koch Institute
RRT	Rapid Response Team
RTA	Road Traffic Accident
RUTF	Ready-to-use Therapeutic Food
SAM	Severe Acute Malnutrition

SARS	Severe Acute Respiratory Syndrome
SOPs	Standard Operating Procedures
SPAR	State Party Self-Assessment Annual Report
STAR	Strategic Tool for Assessing Risks
SURGE	Strengthening and Utilizing Response Groups for Emergencies
SVD	Sudan Ebola Virus Disease
TASS	Transforming African Surveillance Systems
TOT	Training of Trainers
UHP	Universal Health and Preparedness
UHPR	Universal Health and Preparedness Review
UK	United Kingdom
UN	United Nations
UNEP	United Nations Environment Programme
UNM	University of New Mexico
USA	United States of America
WAHO	West African Health Organization
WASH	Water, Sanitation, Health and Hygiene
WCO	WHO Country Offices
WHO	World Health Organization
WHO AFRO	The World Health Organization Regional Office for Africa
WOAH	World Organization for Animal Health
YF	Yellow Fever

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Message from the Regional Director

Dr Matshidiso Moeti
Regional Director, WHO AFRO

“ By leveraging the expertise and resources of various stakeholders, WHO AFRO aims to build a robust and agile EPR infrastructure capable of addressing a complex range of health threats.

As we conclude the first quarter of 2023, sub-Saharan Africa continues to face multiple health emergencies, including multidimensional humanitarian crises caused or exacerbated by violent conflict and climate change. In this

context, the Emergency Preparedness and Response (EPR) cluster of the World Health Organization's Regional Office for Africa (WHO AFRO) is implementing three flagship initiatives—Promoting Resilience of Systems for Emergencies (PROSE), Transforming African Surveillance Systems (TASS), and Strengthening and Utilizing Response Groups for Emergencies (SURGE)—with a due sense of the enormous stakes for human wellbeing and economic prosperity. During the last three months, these initiatives continued to build the physical and organizational infrastructure necessary to monitor, contain, and eliminate disease risks across the continent.

The establishment of the Regional Emergency Hubs in Senegal (to be inaugurated later this year) and Kenya, with a third planned for South Africa, is an especially critical milestone that WHO AFRO continues to work on. During the first quarter, significant gains were achieved in expanding the capacity of the hubs to address ongoing epidemics and identify emerging threats. The Kenya hub continues to play a pivotal role in supporting emergency response efforts, both to disease outbreaks and humanitarian crises, by dispatching emergency health kits and nutritional supplements from its warehouse. This was especially critical in the response to multicountry cholera outbreak and tropical cyclones experienced in some Member States along with other emergency events in the region.

Working closely with Member States, the Africa Centres for Disease Control and Prevention (Africa CDC), and other key

partners, WHO AFRO has focused on strengthening cross-border coordination, information sharing, and technical assistance. This collaborative approach has enhanced the ability of Member States and regional institutions to respond rapidly and effectively to health emergencies by maximizing the impact of their limited resources. Moving forward, WHO AFRO will continue to prioritize capacity building, resource mobilization, and the development of innovative solutions to tackle the unique challenges faced by the region. By leveraging the expertise and resources of various stakeholders, WHO AFRO aims to build a robust and agile EPR infrastructure capable of addressing a complex range of health threats, including the risk of future pandemics. WHO remains committed to ensuring that the AFRO region is adequately equipped to address future health emergencies and safeguarding the wellbeing and prosperity of its people.

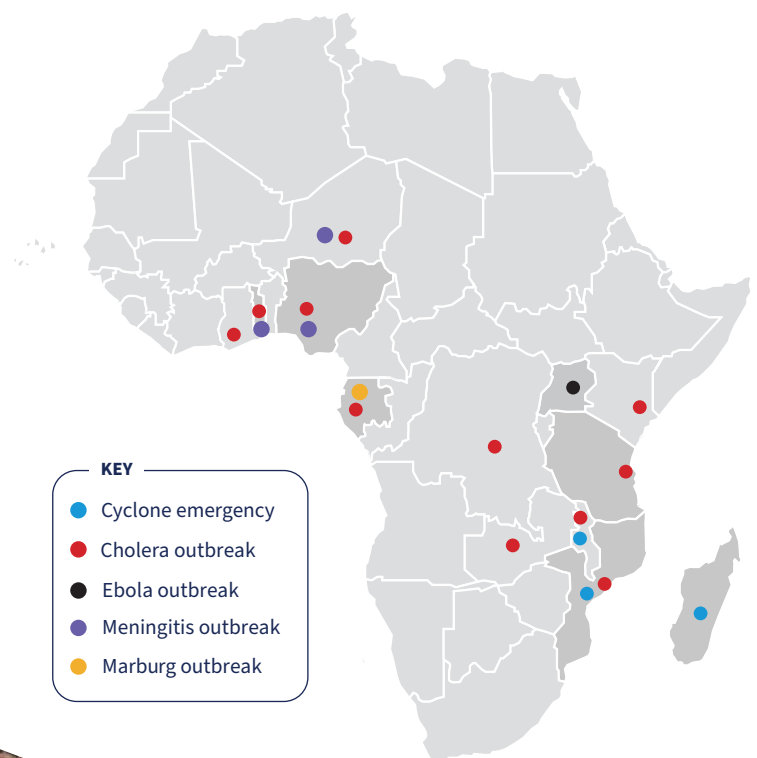
Introduction

Public health emergency preparedness and response efforts in sub-Saharan Africa have gained increasing significance over the past few years due to the growing threat of emerging infectious diseases, natural disasters, and the consequences of climate change.

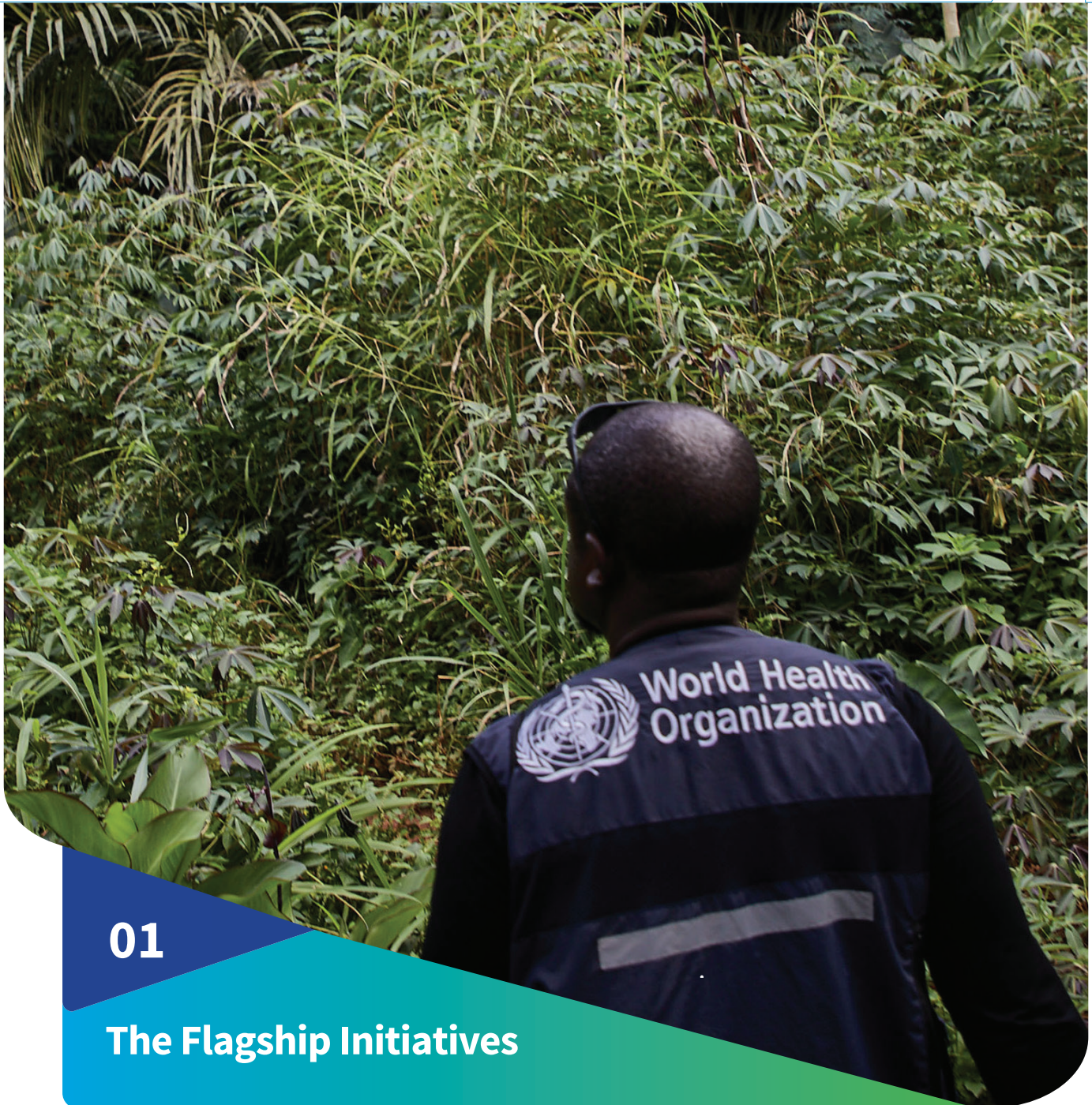
The region's unique challenges, including inadequate healthcare infrastructure, fragile political systems, and widespread poverty, have made it particularly vulnerable to public health emergencies. The collaboration of national governments, regional organizations, and international partners has become essential in addressing these challenges and building a more robust public health infrastructure to mitigate the risks associated with such emergencies.

WHO AFRO's three flagship initiatives are designed to both address immediate public health emergencies and build the resilience of health systems. Key activities include providing technical support for the detection, and response to infectious diseases such as COVID-19, cholera, meningitis, Marburg and Ebola, as well as bolstering the capabilities

of healthcare systems through the implementation of the Integrated Disease Surveillance and Response (IDSR) framework and the One Health Approach. This report provides an update on the implementation of epidemic preparedness and response activities during the first quarter of 2023 (Q1 2023) and highlights WHO AFRO's response efforts to major public health emergencies. Some of the events responded to by WHO AFRO in the quarter are shown on the map below.



The collaboration of national governments, regional organizations, and international partners has become essential.



01

The Flagship Initiatives



**Promoting Resilience
of Systems for
Emergencies (PROSE)**



**Transforming
African Surveillance
Systems (TASS)**



**Strengthening and
Utilizing Response Groups
for Emergencies (SURGE)**

A. Promoting Resilience of Systems for Emergencies (PROSE)



The EPR cluster is working to strengthen emergency preparedness in the PROSE priority countries. These initiatives focus on multisectoral coordination mechanisms in line with the One Health approach (Pillar I); evidence-based plans, policies, and legislation (Pillar II); systems and tools for implementing International Health Regulations (IHR) (Pillar III); workforce development (Pillar IV); risk communication and community engagement (Pillar V); and sustainable and predictable financing (Pillar VI). During Q1 2023, the EPR cluster provided technical support to several countries including Rwanda, Uganda, Benin, Cameroon, Ghana, Mauritius and Sierra Leone, helping them develop and implement health emergency plans, conduct risk assessments, and joint external evaluations (JEEs), and strengthen their health systems. WHO AFRO also facilitated training sessions, tabletop exercises, intra-action reviews, risk communication and community engagement activities, activities to promote the One Health approach, and assessments to enhance emergency preparedness and response capacities in priority countries. The initiative continues to face important challenges, including limited financial and human resources, which must be addressed to ensure its effective implementation.

Evidence-Based Plans, Policies, and Legislation

In Rwanda, the cluster is supporting the development of a National Action Plan for Health Security, the review of the annual operation plan, and the drafting of other relevant EPR plans.

During Q1, the EPR cluster also provided onsite technical support to develop the National Health Emergency Response Operations Plan. A risk assessment was completed, and its findings were used to inform the development of the plan, which includes standard operating procedures for the activation and implementation of response operations to confirm hazards and a plan to address gaps in readiness. The team identified lack of financial resources as the key obstacle to strengthening emergency preparedness.

Efforts to strengthen post-outbreak recovery planning in Uganda are ongoing, with the EPR cluster providing technical support to develop a six-month Post-Ebola Outbreak Recovery and Resilience plan. Launched during Q1, the plan covers surveillance activities and measures to rebuild the health system in the wake of an Ebola outbreak (Figure 1). The After-Action Review (AAR) conducted following the recent Ebola outbreak in Uganda informed the development of a National Infection Prevention and Control (IPC) program (Figure 4). The AAR identified the best practices and documented lessons learned from the outbreak response, including areas for improvement. PROSE remains committed to fully funding and monitoring the implementation of the Post-Ebola Recovery Plan, and continued oversight will be necessary to ensure that the findings of the AAR inform future preparedness efforts.

Figure 1. Maps produced for the Uganda National Post-Ebola Recovery Plan showing (1) the distribution of cases during the latest Ebola outbreak and (2) the locations of previous outbreaks

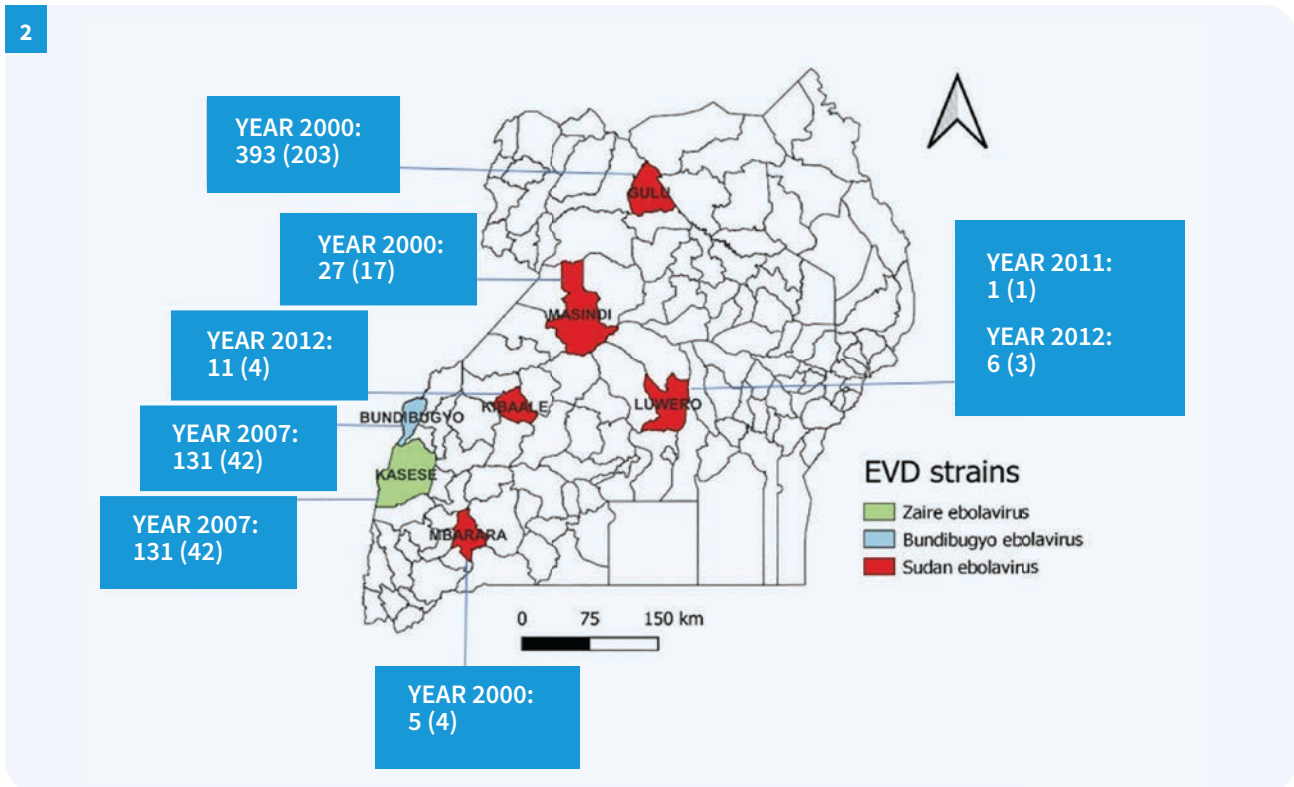
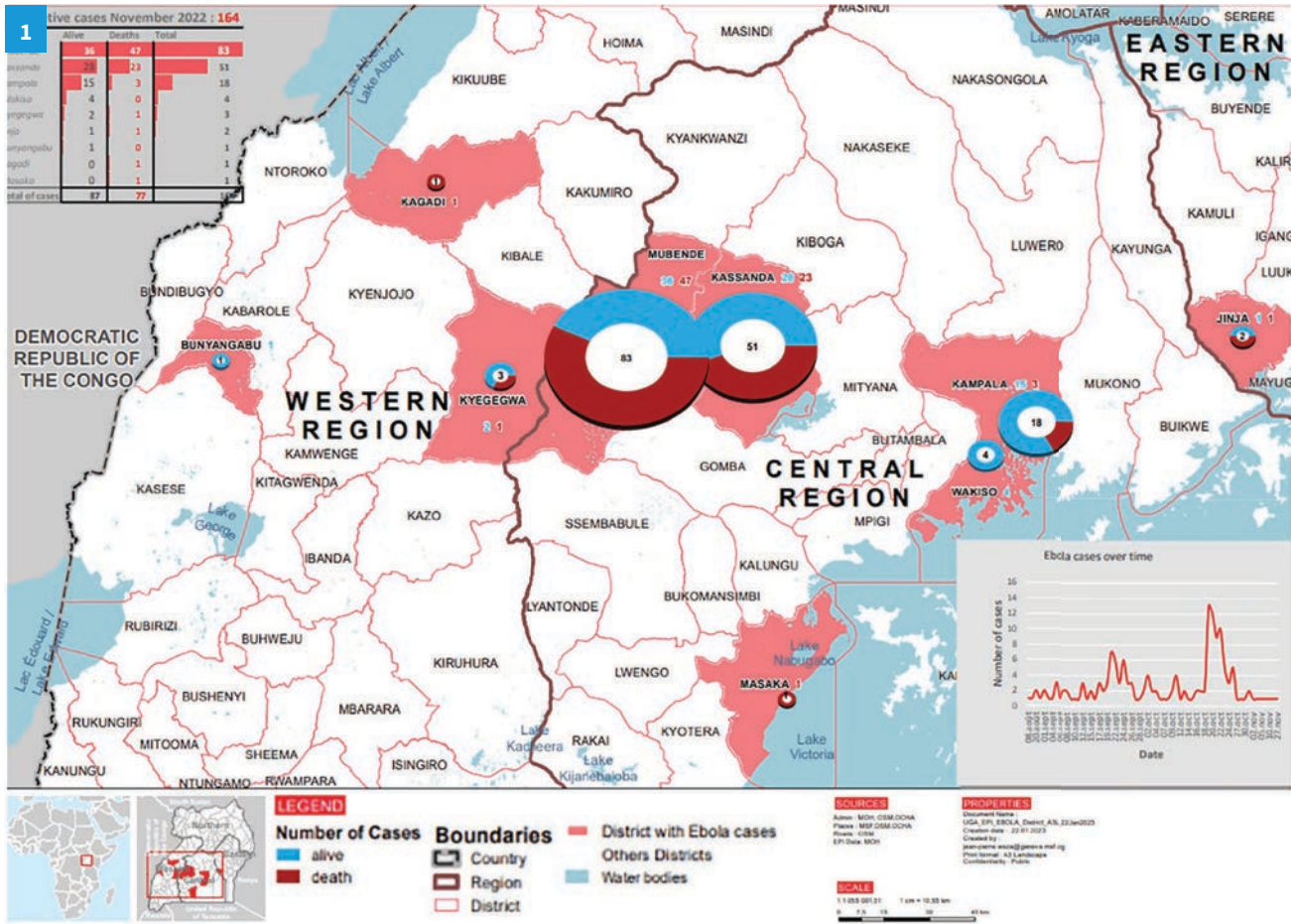
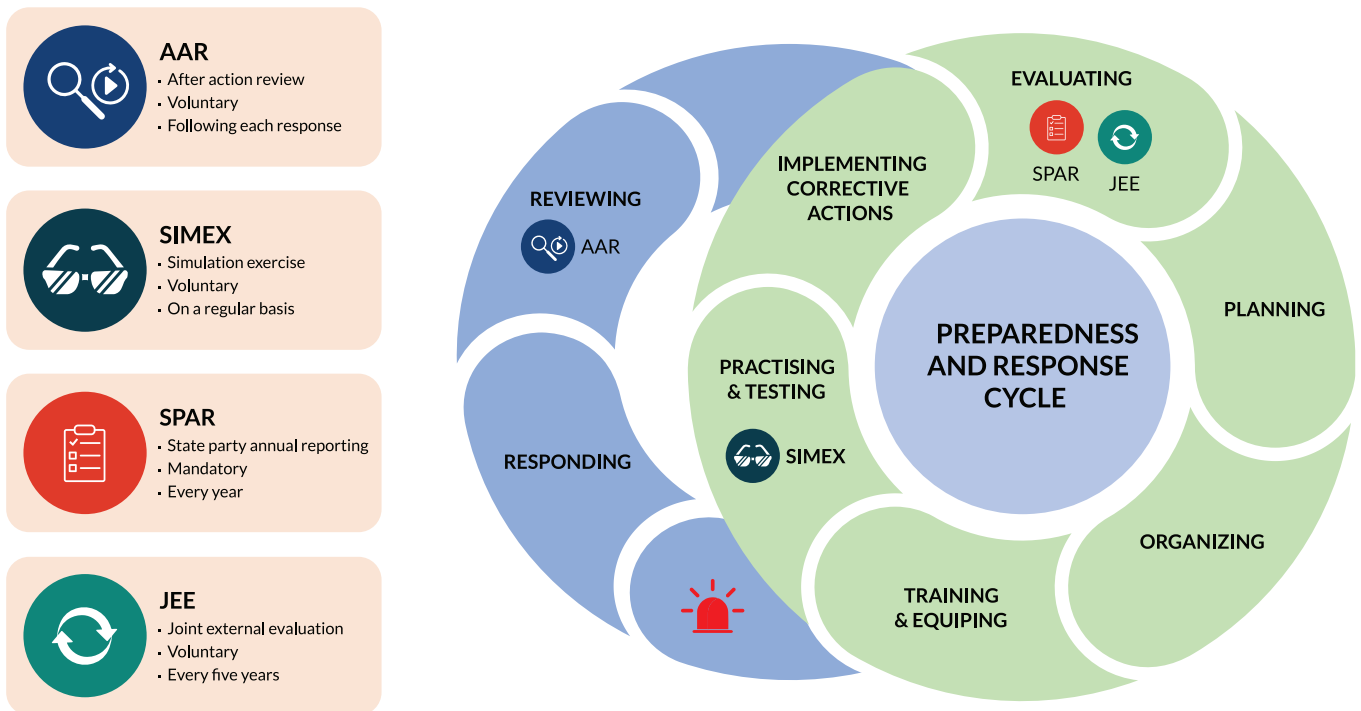


Figure 2. Key Elements of the Preparedness and Response Cycle



In Benin, the cluster continues to facilitate the development of both a contingency and multihazard plan. During Q1, an international consultant was recruited and deployed to support formulation of the multihazard plan and develop an implementation roadmap.

In Cameroon, WHO AFRO is working with national authorities to design a strategic plan for building IPC capacity at border crossings and other points of entry. During Q1, the cluster helped develop a strategy for monitoring events at points of entry and a case-management system. International collaboration remains crucial to this effort.

The cluster also worked closely with national counterparts in Ghana to develop an IPC strategy and a monitoring and evaluation framework. Three virtual training sessions on developing the IPC plan were organized, and a wide range of stakeholders participated.

The EPR cluster continued to strengthen IPC capabilities in participating countries during Q1. In Botswana, a national IPC action plan was developed based on the WHO IPC core components. Technical support was provided during a face-to-face workshop in Botswana held in March. A national IPC situational analysis was conducted, and its findings were used to develop a five-year strategic plan addressing gaps identified in the national IPC program. A series of one-year monitoring and evaluation plans will record progress on the implementation of the five-year plan. However, inadequate

financial and human resources remain a key challenge for IPC implementation.

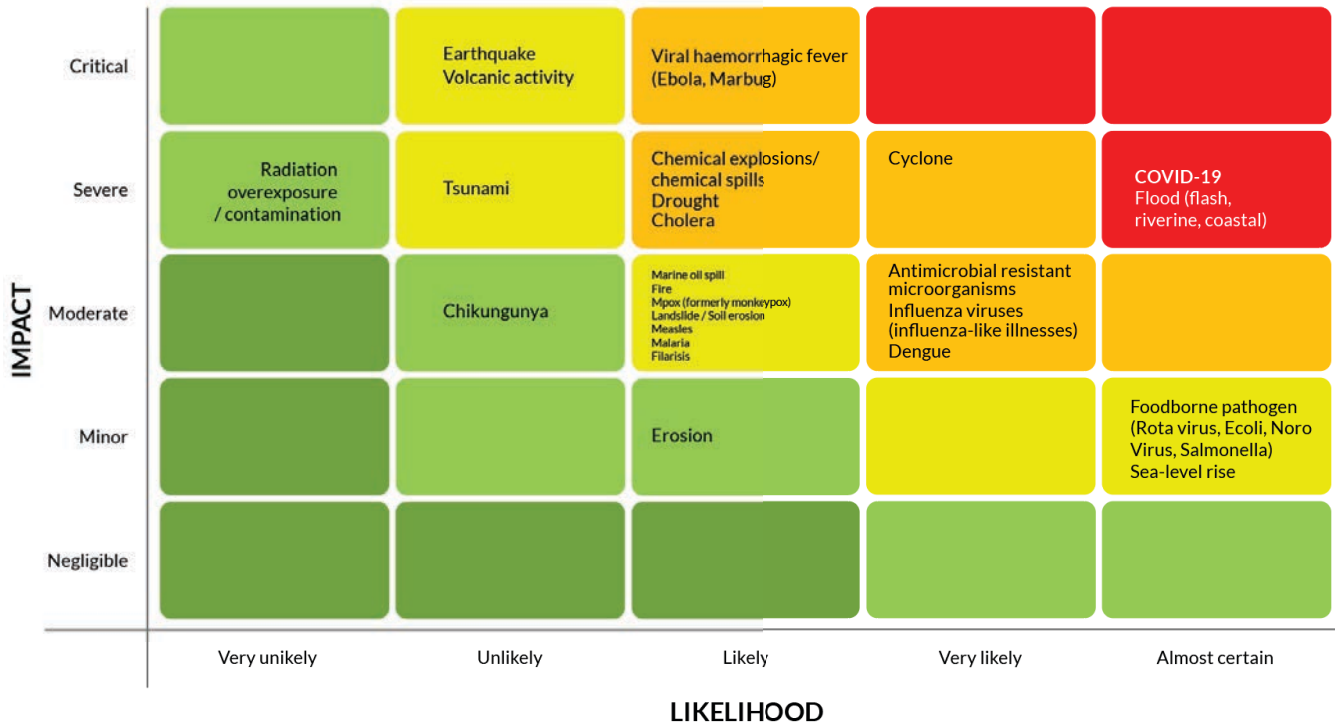
A national IPC action plan was also developed for Uganda, and the EPR cluster trained national counterparts to conduct a situational analysis using the Infection Prevention Control Assessment Tool for Minimum Requirements (IPCAT-MR). The IPCAT-MR was then used to identify critical gaps in IPC at the national level. The cluster also provided guidance on mainstreaming IPC into in-service training curricula and adapted the IPC guidelines developed by WHO AFRO to suit the local context. Additional technical expertise will be required to support the implementation of the IPC action plan.

WHO AFRO continues to support the development of IPC guidelines in Zambia, South Sudan, Namibia, Rwanda, and Lesotho. A guide to formulating national IPC guidelines has been disseminated in all five countries and is helping define approaches to IPC that suit the national context. In February, Zambia successfully produced a set of draft IPC guidelines, though limited human and financial resources to implement the guidelines could weaken the intended impact.

In South Sudan, Namibia, Lesotho, Rwanda, and Madagascar, the EPR cluster worked closely with local health officials to design in-service and pre-service IPC curricula. An IPC in-service curriculum guide was shared with each country, enabling local staff to adapt and contextualize best practices. All five countries developed roadmaps for establishing a national IPC in-service curriculum.

The cluster also provided technical support to the Rwandan and Malian authorities in assessing risks using the STAR tool. Country risk profiles were developed based on the findings, along with risk priorities and risk calendars (Figure 4 and Figure 5). These results will serve as a basis for each country to develop a multihazard plan and contingency plans for priority risks.

Figure 4: Rwanda STAR Assessment: RiskM atrix





Although the COVID-19 pandemic has waned in recent years, Member States need to be prepared for any such emergency events in the future. During March 2023, the EPR cluster provided technical support to implement a COVID-19 Intra-Action Review (IAR) in Comoros. The IAR identified and documented lessons learned to date during the COVID-19 response and presented recommendations for sustaining good practices and addressing ongoing challenges. A COVID-19 IAR was also conducted for Guinea-Bissau, and a national team developed a roadmap for strengthening pandemic response. Interaction reviews (IARs) were also conducted for the cholera outbreak in Cameroon and the drought-induced nutritional and humanitarian crisis in Madagascar.

In Ghana, the cluster is preparing to conduct an after-action review (AAR) of the response to the recent Marburg outbreak. During Q1, a concept note for the AAR was developed, and additional PROSE funds were transferred to finance the review and conduct of the AAR. The national technical team is in place, and the AAR is planned for April 2023.

In multiple countries, the cluster engaged local counterparts in tabletop exercises (TTX) focused on various aspects of EPR during Q1. These included a TTX on the use of the Health Emergency Operation Centre (COUS) procedural manual in Equatorial Guinea, one on crisis communications in Mali, and one on the measles contingency plan in Chad. In Guinea, the cluster trained local health workers on organizing a TTX.

The Joint External Evaluation (JEE) is a key tool for identifying gaps in health systems and emergency preparedness. During Q1, a JEE of IHR implementation capacities was performed in Sierra Leone, with scores

assigned to 52 indicators across 19 technical areas. In Senegal, Guinea and Benin, the EPR cluster briefed national experts on the JEE process, and roadmaps for conducting JEEs were prepared for each country.

To further bolster the analytical underpinnings for health-system strengthening, the cluster helped counterparts in several Member States in preparing to conduct Universal Health and Preparedness Reviews (UHPR). In Sierra Leone, an implementation roadmap for a UHPR pilot was prepared, budgetary resources were transferred, and national stakeholders were briefed on the UHPR pilot process. Similar preparations for UHPRs are underway in the Republic of Congo (ROC) and Cameroon, and the team is working closely with national authorities in the Democratic Republic of Congo (DRC) to prepare a joint risk assessment under the One Health approach.

Workforce Development

Building the capacity of emergency responders and support staff remains a key priority of PROSE. In Kenya, the EPR cluster provided onsite technical support to a Training of Trainers (TOT) session for Ministry of Health staff in January 2023. A team of 53 health workers received training on planning and conducting simulation exercises to test IHR compliance. In Uganda, the cluster provided similar technical support to train 30 health workers on the 2005 IHR and on how to use the Incident Management System (IMS) to respond to malaria outbreaks and other disease risks. High-level ministerial officials were briefed on the IMS, and the design of a malaria-specific IMS was approved.

In Togo, 40 stakeholders, including staff from the National IHR Focal Point, participated in an onboarding workshop.

Risk Communication and Community Engagement (RCCE)

The cluster provided technical guidance to RCCE focal points in all PROSE countries on communications related to COVID-19, Ebola, cholera, Marburg, polio, measles, and vaccination. This guidance was tailored to the local context and informed by community feedback provided both online and in person. Biweekly virtual meetings were held with the RCCE focal points to review their messaging and provide appropriate guidance. The establishment of government-led community feedback mechanisms allowed for the routine incorporation of performance data into the RCCE strategy. RCCE support was especially critical in countries facing disease outbreaks, and experiences, lessons learned, and best practices were shared across countries. Going forward, additional funding will be necessary to provide adequate RCCE support, including human resources, as local health staff in many participating countries lack sufficient skills and expertise in this area.

RCCE was a key target of capacity-building efforts and the development of the Community Engagement Strategy for the AFRO region during Q1. The Senegal hub recruited an international consultant to support the implementation of RCCE activities. In Niger, the cluster worked with local counterparts to develop and validate the RCCE One Health plan. In Benin, RCCE training was provided to 177 stakeholders, and high-level advocacy efforts were directed to ministry executives and departmental staff on issues related to the One Health approach. The RCCE team monitored the implementation of PROSE activities in Côte d'Ivoire, Congo, Ghana, the Central African Republic (CAR), Burkina Faso, and Mauritania. The team also supported the preparation of the JEE in Sierra Leone. The cluster partnered with the WHO's Universal Health Coverage/ Universal Health Populations (UHC/UHP) cluster to develop the strategy "Strengthening Community Protection and Resilience: Regional Strategy for Community Engagement, 2023-2032 in the WHO Region," which has been slated for adoption during the 2023 Regional Committee meeting for Africa.

Sustainable and Predictable Financing

Under the sustainable and predictable financing pillar, the EPR cluster supported Member States in preparing proposals for the Pandemic Fund. The Pandemic Fund is a dedicated stream of additional long-term funding available to the International Development Association (IDA) and International Bank for Reconstruction and Development (IBRD) eligible countries. The fund finances investments and technical support at the national, regional, and global levels related to pandemic prevention, preparedness, and response (PPR) functions. The first call for expressions of interest was issued on February 3, 2023, and submissions were received from 35 countries in the WHO AFRO region. On March 3, 2023, the fund opened its first call for proposals from eligible countries, regional entities, and implementing agencies.

WHO formed a Pandemic Fund Coordination Committee, which includes various clusters within AFRO, to provide technical support to Member States for developing proposals to strengthen surveillance systems, laboratory capabilities, and workforce capacity. The committee set up clear processes to foster engagement within the various WHO AFRO teams, work with technical reviewers, and ensure consistent and clear communications with Member States. WHO AFRO also established a mechanism for coordinating the implementing entities (Table 1).

Table 1: Activities done to support Member States for Pandemic Fund proposal submission

Phase 1 Pre-submission of proposals by countries	Phase 2 Submission of proposals by countries
<ul style="list-style-type: none"> Establishing WHO AFRO Pandemic Fund Coordination Committee Soliciting and recruiting a technical team of reviewers Enlisting the support of a project management team Drafting guiding principles and sharing guidance on Pandemic Fund application process with Member States 	<ul style="list-style-type: none"> Onboarding technical experts on the country application review process Developing and deploying checklists and progress trackers Allocating countries to technical reviewers for in-depth reviews and feedback Providing ongoing business and project support Organizing webinars with countries Developing and disseminating FAQs Maintaining contact with project management team

PROSE Implementation at the Kenya Hub

A 2022 review of PROSE implementation at the Kenya emergency hub formed the basis for a 2023 action plan. The plan identified unfinished activities to be completed during the year, additional priority countries to target, and urgent interventions in these countries. The plan emphasized the need for clear indicators to measure EPR capacity. It also underscored the importance of hiring a dedicated PROSE consultant for the Kenya emergency hub, as well as a program officer tasked with fostering the interagency coordination necessary to adopt the One Health approach at the country level.

B. Transforming African Surveillance Systems (TASS)



Scaling Up the Implementation of Integrated Disease Surveillance and Response Strategy

In Botswana, the EPR cluster continued to roll out the WHO's 3rd generation Integrated Disease Surveillance and Response (IDSR) strategy. IDSR trainings were held at the national level and sub-national level in 14 health districts. Up to 80% of facilities in the training districts had one trained staff member, but not all trained staff member, but not all facilities had a representative. The EPR cluster also worked to strengthen IDSR supervision and review mechanisms by conducting district support visits and updating reporting methodologies.

In CAR, the cluster helped develop and validate the technical guide for integrated disease surveillance and response at the operational level. The team also elaborated and validated the IDSR technical guide, and funding options are being explored to finalize the guide. A term of reference (ToR) to expand community-based surveillance was also prepared and forwarded for funding.

In Kenya, the EPR cluster continued to support the strengthening of existing sentinel surveillance sites and the establishment of standard COVID-19 sample collection and reporting procedures. Refresher trainings were held, field monitoring visits were conducted, and laboratory supplies were provided. The Ministry of Health is working with WHO and other partners to double the number of severe acute

respiratory infection (SARI) sentinel surveillance sites, from eight to 16. The EPR cluster helped assess the capacity of five county hospitals¹ to perform sentinel surveillance. The assessment involved collecting routine surveillance data and evaluating laboratory infrastructure and systems. The current SARI sites have integrated COVID-19 testing into the existing platform, and a proposed increase in the number of sites is expected to allow for the collection of nationally representative data. IDSR training for point-of-entry (POE) staff continued in Q1. POE staff joined a national training-of-trainers (TOT) session, and selected teams participated in the cascaded county-level TOT sessions held in February and March. Overall, two POE teams were trained during the quarter, along with ten other stakeholders. The remaining POE staff are slated to join the sub-county trainings defined in the workplan.

TASS continued to support IDSR TOT activities during Q1. Despite a delay caused by scheduling conflicts, the team trained 20 trainers from Niger, while another 22 trainers from the Republic of Congo and 59 from Togo also received IDSR training over the period. In Madagascar, training workshop for surveillance officers were held at the district level in Madagascar. District focal points were trained in IDSR as part of the surveillance functions included in their ToRs. In CAR, terms of reference were drafted and submitted, and funds were available for implementation.

The cluster also continued to mass produce and disseminate IDSR tools and training materials. In Chad, a third edition of the IDSR guidelines was produced, and 210 copies were presented to health responders. In addition, 3,000 copies of surveillance tools for data collection were produced and distributed.

In Mauritania, the participant, trainer, and IDSR guides were translated into French and Arabic, and 700 IDSR guides were distributed.² In Madagascar, the cluster produced image boxes for defining disease cases and events, a booklet outlining surveillance-management tools both for public and private health facilities, and up-to-date image and Outil de Gestion boxes from the 3rd edition of the IDSR guide. In Niger, tools and materials were produced and made available for cascade trainings. In the Republic of Congo, local communication specialists helped design media tools to support cascade training.

A système d'information sanitaire (SIS) Forum was held in Madagascar, which identified 44 relevant projects for the Strategic Plan for Strengthening the Health Information System (Plan Stratégique de Renforcement du Système d'Information Sanitaire, PSRSIS) 2023-2027 and elaborated the theory of change for the SIS. In Chad, a training workshop on IDSR 3 tools was organized, and 40 participants were trained. Cascade TOT at the intra-national level continued in Niger, with 98 trainers trained to date.

The EPR cluster investigated a suspected mpox outbreak in Congo and produced an investigation report. The cluster continues strengthening passive surveillance in the risk areas for mpox in the department of Likouala. Mapping exercises of the country's seven official points of entry, health units, and public and private health facilities formed the basis for a rapid assessment of the health sector's capabilities.

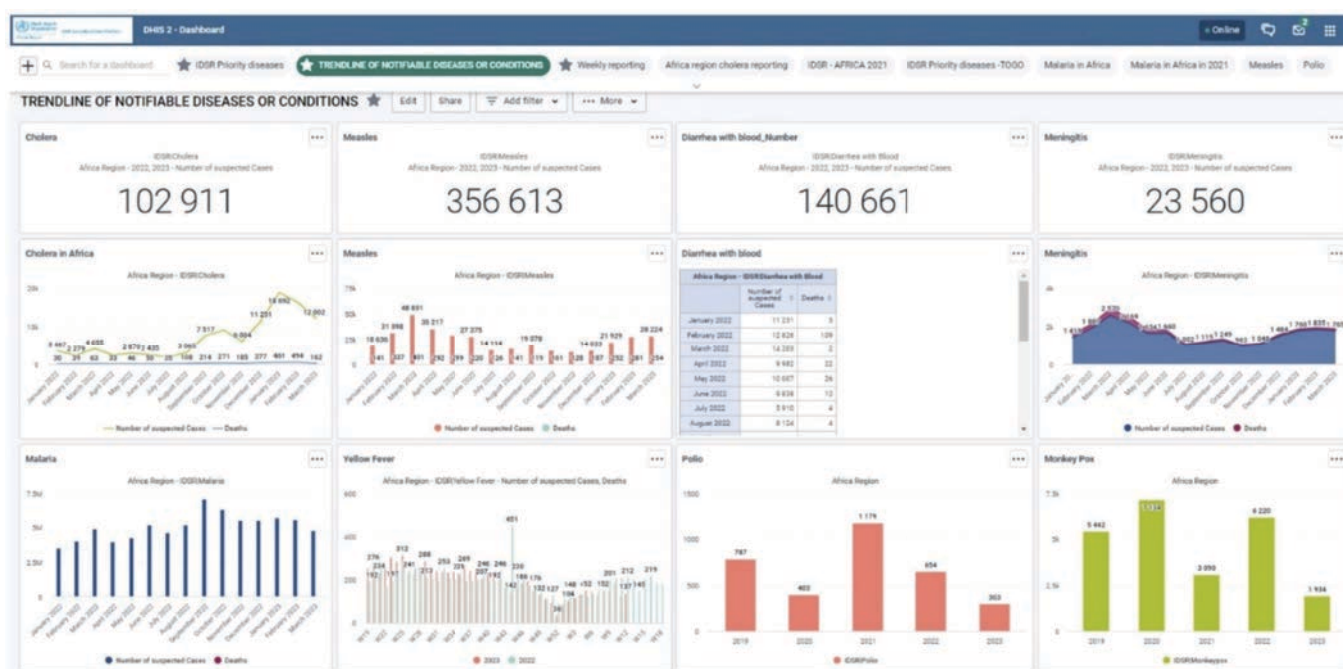
Data Management and Digitization

As part of its efforts to develop a real-time electronic IDSR system in Botswana, the cluster continued to expand access to the District Health Information Software 2 (DHIS2) platform at the facility level. DHIS2 is now operational at the national level and in some facilities. During Q1, the EPR cluster continued to train personnel in utilizing the DHIS2 platform. A concept note for developing web-based platform and dashboard for the IDSR was drafted and agreed upon with Botswana's Ministry of Health.

Figure 5: IDSR Centralized Data Platform Interface



Figure 6: Sample Dashboard of the IDSR Centralized Data Platform in DHIS2



In Kenya, digital learning platforms allowed for continual training and supported the creation of a community of practice around public health preparedness and response. A technical assessment of the facilities to be used for a new digital learning platform was completed and shared with the Kenyan Ministry of Health, and the necessary renovations are currently in the approval process. During Q1, equipment procured with WHO AFRO support began to arrive in country.

In Mauritania, 22 trainers were identified to support the digitization of epidemiological surveillance through early warning, alert and response system (EWARS), along with 105 tablets, 15 computers, and one EWARS kit available. All monitoring tools are being integrated into EWARS. Monthly meetings are being held at the central level to harmonize surveillance data between laboratories, the Directorate of Strategic Information and Epidemiological Surveillance, and the Ministry of Health. During Q1, harmonized national data on vaccine-preventable diseases for 2022 was reviewed and validated.

In Niger, surveillance, laboratory, and data-manager focal points are being established at all levels, with internet packages used to facilitate data management and sharing. These internet packages were analysed, and an internal memo was prepared on the necessary funding. The timeliness and completeness of IDSR weekly data are improving, and a line list of cases is being prepared. TASS is also providing regional health facilities with data-management equipment, and during Q1 data-collection materials were distributed to health facilities.

In CAR, TASS continues to develop integrated tools for identifying and reporting on disease risks following the One Health approach. During Q1, ToRs for funding to support this effort were drafted and

validated. The Surveillance Department received computers and other digital hardware, and further requests for equipment are being prepared and submitted. All IDSR reporting forms are now available in DHIS2, which has been operationalized for weekly monitoring of aggregated data. Data is being entered at the district level using updated forms, and the installation and configuration of the IDSR/ Ebola aggregate monitoring package continued during Q1. A request for tablets for the 12 sentinel sites monitoring influenza, rotavirus and bacterial meningitis was sent to WHO, and the procurement process is underway. Training sessions on data management and the digital vaccine-preventable diseases surveillance package are being prepared. A total of 42 focal points, 42 managers, 42 regional and district management team members, 12 sentinel-site surveillance agents, and ten staff and surveillance managers from the Ministry of Health are expected to be trained over five days. Monthly meetings on harmonizing surveillance and laboratory databases are being held with the national laboratory, IPB, and surveillance sites. Strengthening Diagnostics and Genomic-Sequencing Capabilities

Strengthening Diagnostics and Genomic-Sequencing Capabilities

In Madagascar, TASS is facilitating the purchase of test kits, reagents, and consumables for genomic sequencing. During Q1, two groups of Laboratoire d'Analyses Médicales Malagasy (LA2M) biologists were trained in sequencing techniques and bioinformatics analysis. The procurement process for computers and intranet hardware for the laboratory network continued during Q1.

In CAR, the cluster drafted ToRs to develop guidelines for collecting, storing, packaging, and transporting human and animal samples and for transporting laboratory samples from the operational level to the central level. Requests for equipment and office supplies

for the Epidemiological Surveillance Department were prepared and submitted during Q1. The purchase of sequencing equipment for reference laboratories (Eliza, PCR, Sequencing) and adequate means of transportation completed the operationalization process, and genomic monitoring was officially launched in CAR.

The EPR cluster continued to strengthen the capacity of laboratory systems in Mauritania. The cluster acquired 25,000 viral transmission mediums (VTMs) for nasopharyngeal samples and 36 micropipettes of volumes of 10, 100, and 1000 microliters and requested additional materials and reagents for the biological confirmation of epidemic prone diseases. The cluster also ordered materials for laboratories in Niger, including freezers for biosecurity; meningitis-related supplies in Togo; and various laboratory supplies, reagents, and consumables in the Republic of Congo. To support the creation of a national biobank in the Republic of Congo, the cluster held preparatory meetings with the national laboratory.

Workforce Development

The EPR cluster continued to recruit additional skilled workers in Botswana. Every district now has a designated surveillance officer, but the government has yet to formally absorb these personnel. WHO AFRO will continue to support and collaborate with the surveillance officers while advocating for their formal incorporation into the national health system.

Improving Systems for Monitoring and Evaluating IDSR Performance

The EPR cluster continued to strengthen performance monitoring in Madagascar. During Q1, US\$2 per month in telephone credit was allocated to surveillance managers at the central level and focal

points at the regional and district levels to assist in monitoring the performance of health facilities. Performance improvements were also observed in the weekly monitoring reports. To inform decision-making, monthly IDSR and semi-annual SIS bulletins are being prepared and shared with relevant directorates and programs. ICT capacity-building efforts at the regional level focused on using data-management applications including DHIS2 RMA, DHIS2 surveillance, and material management systems. The functionality of the reporting system and the performance of the SIS both improved substantially during Q1.

Advocacy and Policy Dialogue to Ensure Sustainable and Predictable Funding

In Niger, the cluster continues to hold monthly surveillance-coordination meetings. During Q1, a ToR was prepared for virtual meetings and working groups to develop and validate the national weekly epidemiological surveillance bulletin. To raise the profile of IDSR implementation and help mobilize funds, the cluster produced a documentary on IDSR and organized awareness-raising activities for partners.

In CAR, meetings with ministers responsible for human and animal health, finance, education, international cooperation, and territorial administration were organized to strengthen cross-sector collaboration and pool resources for the surveillance and response to zoonotic diseases in line with the One Health approach. The cluster also organized a meeting with agency heads to mobilize additional resources for IDSR implementation.



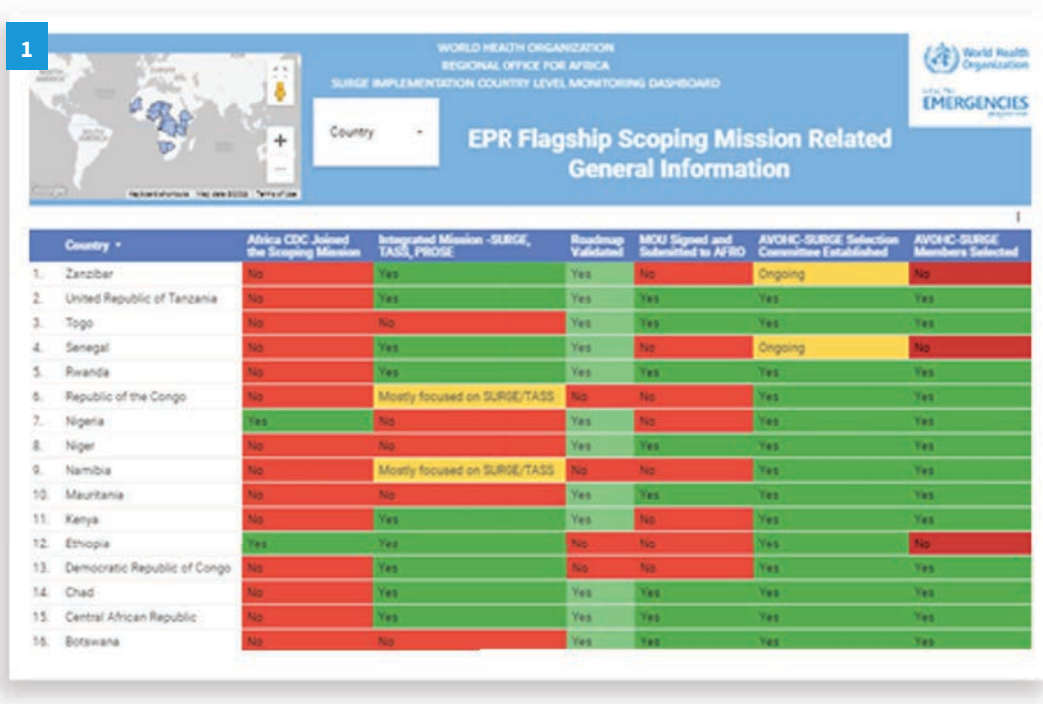
C. Strengthening and Utilizing Response Groups for Emergencies (SURGE)

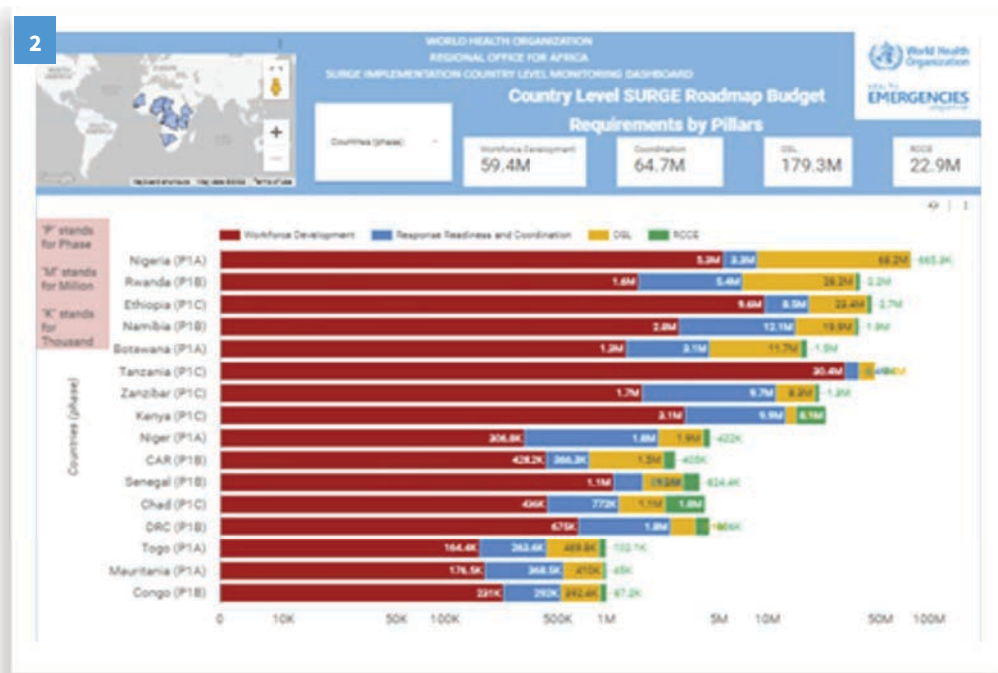


In Q1 2023, significant progress was made in implementing the SURGE flagship. In Q4 2022, scoping missions were completed in 15 countries (Figure 5). These missions, which involved consultations with over 122 high-level government officials, helped the Member States develop a two-year roadmap to mobilize resources. WHO AFRO is now supporting and monitoring the validation and implementation of the roadmap. To date, eight of the 15 countries have signed a Memorandum of Understanding (MoU) with WHO.

Monthly calls with Member State representatives were held to track implementation progress, address challenges, and discuss the support needed for the SURGE flagship. An online tracker was developed to monitor the activities undertaken as part of the country roadmap and improve accountability. In parallel, an interactive dashboard was created to oversee progress at the regional level and offer support to implementing countries (Figure 7).

Figure 7: SURGE Dashboard: (1) Scoping Missions and (2) Budget Breakdown





Workforce Development

This pillar focuses on rapidly mobilizing skilled African responders to shorten response times to public health emergencies. The goal is to establish a 3,000-member multidisciplinary team that can be deployed at the national and sub-national levels within 24-48 hours. During the review period, at least 50 Africa Volunteer Health Corps and Strengthening and Utilizing Response Groups for Emergencies (AVoHC-SURGE) members were trained in each of the following countries: Namibia, Rwanda, Tanzania, Congo, Kenya, Chad, and DRC. Onboarding trainings were also completed in Namibia and Tanzania during Q1.

To build the capacity of the AVoHC-SURGE members and increase their knowledge of emergency response techniques, the regional office conducted series of webinars to complement the standard in-person training. Over 250 participants attended weekly webinars on understanding the role of PHEOCs, utilizing the IMS and WHO's Emergency Response Framework, providing psychosocial support during a crisis, conducting laboratory-sample management during acute haemorrhagic fever syndrome, managing waste during field investigations into potential outbreaks, and evacuating suspected communicable disease cases by Rapid Response Teams. The webinars were conducted in English, French, and Portuguese. The Namibia and Malawi team held trainings for Emergency Medical Teams (EMTs). These sessions, which included training on simulation exercise (SimEx) engaged over 50 participants, including doctors, health practitioners, and paramedics from the Ministry of Health. A two-day EMT orientation for Ministry of Health directors and decision-makers was also conducted in Namibia. In Malawi,

EMTs from the United Kingdom supported the training of local health workers. AVoHC-SURGE responders were immediately deployed to support the response to a multicountry cholera outbreak and several tropical cyclones.

A robust, interactive, and interoperable tool for managing AVoHC-SURGE members was developed and launched. The tool is currently undergoing security and vulnerability testing by WHO. A virtual training was conducted for 286 participants from eight countries on how to use the tool. In-person training sessions were also integrated into Tanzania and Kenya's PHEOC and IMS trainings. The database lists 841 AVoHC-SURGE members from 11 countries and 250 Triple-E responders.

Four countries³ have started utilizing trained national AVoHC-SURGE members to investigate and respond to disease outbreaks. During the period under review, AFRO deployed trained AVoHC-SURGE members from Rwanda and Botswana to support cholera response efforts in Malawi and Kenya. In Niger, six ministers issued a joint decree to formalize the functionality of the AVoHC-SURGE team.



Emergency Response Preparedness and Coordination

In collaboration with its partners, WHO AFRO continues to help Member States strengthen their PHEOCs by deploying technical experts and developing standard operating procedures and manuals. Niger, South Africa, and Cape Verde received support for PHEOC operationalization through the deployment of experts, the preparation of situational analyses, the development of implementation plans and legal frameworks, and the creation of standardized procedures and guidance documents. Simulation exercises were used to test the functional effectiveness of the PHEOCs. PHEOC and IMS staff in these three countries were trained in public health emergency management, and a roster of surge staff was created.

Through the African Public Health Emergency Operations Centres Network (AFR PHEOC-Net), WHO AFRO also supported AVoHC-SURGE trainings on PHEOC operations and the WHO Emergency Response Framework in the Republic of Congo, DRC, Rwanda, Tanzania, and Kenya. DRC, Rwanda, Tanzania, and Kenya. In Q2, WHO AFRO will continue to develop and operationalize PHEOCs in South Africa, the Republic of Congo, and DRC. In parallel, efforts are underway to implement the Electronic Public Health Emergency Management software system in Togo, which is designed to facilitate the flow of vital information during health emergencies and enable timely decision-making.

Operations Support and Logistics

To strengthen and equip national response efforts, eight vehicles were provided to each of the Member States implementing SURGE. Nine of these countries transferred ownership of the vehicles to the national authorities. During January 23-28, 2023, WHO AFRO

and Africa CDC delivered a hands-on supply-chain and operations management training in Nairobi. The training included 85 participants from six Member States.⁴ The training aimed to equip Member State supply chain and operations specialists with the necessary skills to effectively respond to emergencies in the field. Topics covered included supply chain management, forecasting, data analytics, health logistics, and operations. Entry and exit tests were conducted to measure the training's impact. Three outstanding participants were subsequently deployed to support cholera and cyclone response efforts in Malawi.

In Q1 2023, the WHO AFRO Operations Support and Logistics team (OSL) shipped nearly 196 metric tons of emergency supplies worth US\$2.1 million to 13 AFRO countries. These supplies supported response efforts to outbreaks of cholera and Marburg disease, as well as a tropical cyclone. The Kenya hub organized two air charters to support the cholera response in Malawi. Within 72 hours of the initial request, these charters had shipped 48 metric tons of cholera supplies with a total value of US\$221,206 to the affected country.

Risk Communication and Community Engagement

The Risk Communication and Community Engagement (RCCE) program has continued to support health ministries in developing effective messaging strategies and outreach campaigns to underpin their outbreak responses. In Q1, the WHO RCCE's experts played an especially critical role in community engagement during the Marburg virus and cholera outbreaks. WHO AFRO also worked closely with the Government of Niger to develop and validate its RCCE strategic plan and formulate standard operating procedures under the RCCE intervention framework.

Lessons Learned during Quarter One



SURGE activities during Q1 highlighted the crucial importance of workforce development. Trained responders from participating countries are now able not only to assist in emergency response efforts within their national border but also to intervene in regional health crises, such as outbreaks of cholera in Malawi and Kenya and Marburg virus in Tanzania. The regional database of the EPR workforce provides valuable information on trained responders, including their areas of expertise and current locations, enabling WHO, government officials, and partners to make informed deployment decisions during emergencies.

Another significant lesson learned is the importance of building on existing systems and partnerships, as the commitment demonstrated by participating governments has played a key role in building stronger emergency preparedness and response systems. SURGE strengthens existing health workforces through training conducted in collaboration with Africa CDC and other partners. SURGE also promotes collaboration across sectors, minimizing the duplication of effort, which is vital in the context of limited resources.

Response to Graded Events



Eight new major public health emergencies were reported during Q1 2023.



These include a **grade-3 multicountry cholera outbreak affecting 13 countries, a grade-3 Marburg outbreak in Equatorial Guinea, and grade-2 outbreaks of Marburg in Tanzania, meningitis in Nigeria and Togo, and diphtheria in Nigeria.**

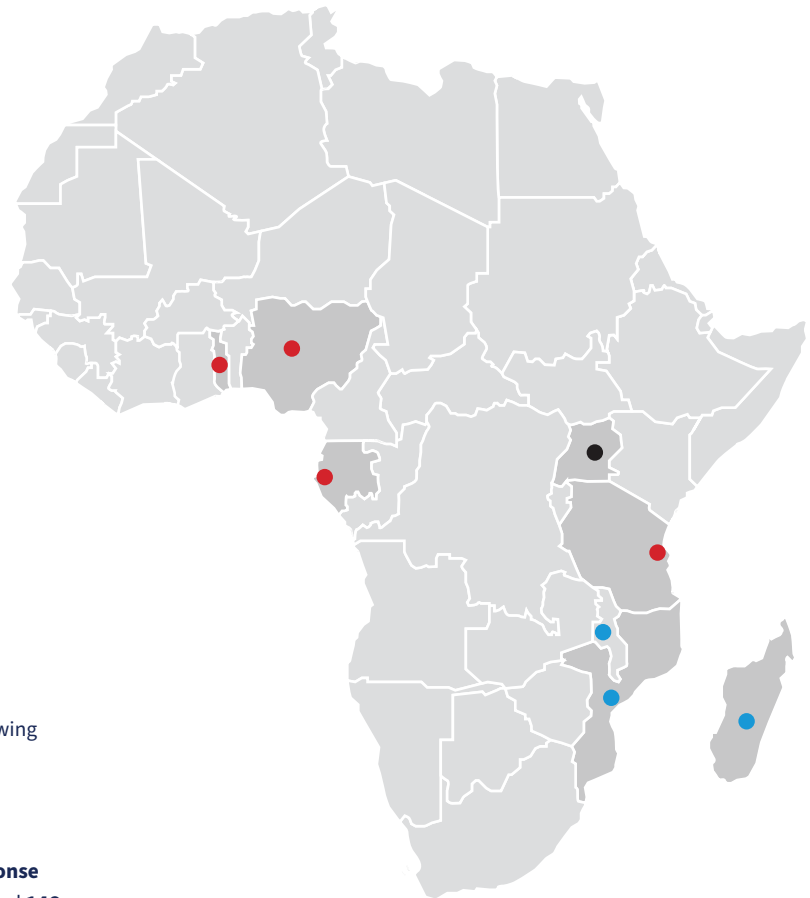


In addition, tropical cyclone Freddy caused a grade-2 emergency in Mozambique, and Malawi, while tropical Cyclone Cheneso caused a grade-1 emergency in Madagascar.



During this period, the Sudan Ebola Virus outbreak in Uganda was contained, and following a robust government-wide response effort that lasted 113 days, the end of the outbreak was declared on January 11.

To augment the Ugandan government's response efforts, WHO deployed over 66 international and 146 national experts, dispatched medical and infection-control supplies worth US\$2.9 million, distributed 128 vehicles across the nine affected districts, and provided US\$7 million in financing from the contingency fund for emergencies.



KEY

- Cyclone emergency
- Ebola outbreak
- Multicountry cholera outbreak



Multicountry Cholera outbreak

A multicountry cholera epidemic continues to pose a significant public health challenge, with 13 countries reporting cases. Within the first 20 days of 2023, the number of reported cholera cases in the region had reached 30% of all cholera cases reported in 2022. This surge in cases occurred amid a complex context of natural disasters, conflicts, and other health risks. Moreover, simultaneous cholera outbreaks in other WHO regions reduced the availability of medical supplies and other resources in the affected countries.

On January 27, the multicountry cholera outbreak in the AFRO region was declared a global grade-3 public health emergency. Resources across the three levels of WHO were mobilized to support the affected countries. Incident management teams and support teams were activated, and 73 experts were deployed to Malawi (60), Kenya (five), Mozambique (eight). Over 455 metric tons of critical cholera supplies, including intravenous fluids, were delivered to Malawi and Mozambique, DRC, Ghana, Kenya, and Zambia,

while US\$5 million in emergency funding was disbursed to Malawi, Kenya, and Mozambique. Despite the global shortage of oral cholera vaccines, 3.4 million doses were delivered to DRC, Kenya, and Mozambique. In Malawi, using both imported and locally sourced supplies, the WHO Logistics team designed, constructed, and operationalized seven cholera treatment facilities with a total of 164 beds.

By March 30, 145,121 suspected cholera cases had been reported, including 3,249 deaths. The outbreak in Malawi, which had contributed over 39% of all cases and 51% of all deaths, was under control, as new cases and deaths had declined for three consecutive weeks. However, the impact of Cyclone Freddy, combined with poor sanitation, unreliable water supplies, and the increased movement of people across borders, continues to pose enormous challenges, and further short-term interventions and long-term support will be necessary to keep the outbreaks under control and protect vulnerable populations.



145,121
suspected cholera
cases



3249
deaths



39%
of all the cases and 59%
of the deaths were from
Malawi



Diphtheria, Yellow Fever, and Rift Valley in Niger

Niger recently experienced outbreaks of diphtheria, yellow fever, and Rift Valley fever, with cases reported in the Tahoua, Maradi, and Zinder regions, respectively. In response, the Directorate of Surveillance and Response to Epidemics (DSRE) assembled a crisis cell and deployed three investigation teams from the EPR cluster to investigate the outbreaks, assess and determine the risk factors, and to respond to the outbreak.

Investigation teams successfully sampled all 26 suspected diphtheria cases, the confirmed yellow fever case, and the confirmed Rift Valley fever case, while also capturing mosquitoes to identify disease vectors. This effort led to the discovery of eight additional suspected diphtheria cases and 54 contacts, all of whom received prophylaxis. Sixteen contacts and ten animals were also sampled as part of the investigation into the Rift Valley fever case. The CERMES mobile laboratory cultured the samples in the field, and the team decontaminated affected houses and materials. A sensitization and advocacy meeting was held in the camps where cases were reported, with the involvement of administrative and customary authorities. The diphtheria outbreaks in Tahoua have been brought under control, and no new cases of yellow fever or Rift Valley fever have been reported. The EPR cluster's entomologists captured and identified *Aedes* mosquitoes as vectors of the diseases in affected households.



26 suspected
diphtheria cases



9.4 million people
require
humanitarian
assistance



4.9 million
of them that require
humanitarian assistance
are children

Humanitarian crisis: South Sudan

In 2023, an estimated 9.4 million people in South Sudan, including 2.2 million women and 4.9 million children will require humanitarian assistance and protection due to the devastating effects of a multifaceted crisis marked by ongoing violence, food insecurity, flooding, and public health emergencies. Floodwater levels have remained high across much of the country, negatively affecting livelihood activities, increasing the risk of waterborne diseases, and disrupting the provision of essential services. In parallel, intercommunity violence has intensified, displacing thousands of people and exacerbating health risks. WHO AFRO continued to support response to infectious disease outbreaks such as cholera and to support access to essential health services for displaced populations.

Measles outbreak

In early 2023, a measles outbreak occurred in Botswana, with the epicenter in Chadibe. The outbreak was traced back to two children who had travelled to a district in Zimbabwe experiencing a measles outbreak. The AVoHC-SURGE team investigated and confirmed the existence of the outbreak, with 13 laboratory-confirmed cases and several epidemiologically linked cases.

Key findings from the investigation:



The outbreak primarily affected unvaccinated individuals, with only 02 cases attributed to vaccine failure.



Affected age range was 2 to 24 years, with 60% being male.



Surveillance gaps were identified, suggesting the true number of cases might be underreported.



The response to the outbreak was uncoordinated, necessitating urgent action to strengthen coordination efforts.



Recommendations based on the investigation:



To contain the measles outbreak in Botswana, it is crucial to implement the recommendations made by the AVoHC-SURGE team. This will help mitigate the impact of the outbreak and prevent further spread, especially among vulnerable populations. Strengthening the coordination of response efforts, enhancing surveillance, and promoting vaccination campaigns are essential steps in addressing this public health emergency.



750,000
MenACYW135
administered



02
countries reported
meningitis outbreak

Meningitis outbreak

During Q1, Togo, Nigeria, and Niger all reported meningitis outbreaks. Togo's outbreak was assessed as grade-2, while Nigeria's was grade-1, and Niger's was ungraded. The outbreak in Togo was caused by streptococcus pneumonia, while the outbreaks in Nigeria and Niger were due to Neisseria meningitis. In coordination with the vaccine-preventable diseases team, technical support was provided to strengthen case management, surveillance, and investigation. Doses of ceftriaxone were provided by WHO's International Coordination Group, and reactive vaccination campaigns using MenACYW135 conjugate vaccine reached over 750,000 people. A drastic reduction in cases was observed in each affected country two weeks after the start of the vaccination campaign.

Marburg outbreak

Equatorial Guinea reported its first-ever outbreak of Marburg virus on February 13, 2023, following confirmatory tests at the Institute Pasteur Laboratory in Dakar. WHO assessed the outbreak as posing a very high risk at the national level, a high risk at the regional level, and a low risk at the global level. The event was declared a grade-2 public health emergency on February 15. By March 30, a total of 14 cases had been confirmed, including 10 deaths. As the national authorities lacked previous experience with Marburg, WHO rapidly deployed 25 experts to support the Ministry of Health teams responsible for investigation, contact tracing, case management, infection prevention and control, and community engagement. In addition, US\$500,000 in funding was provided to support field operations; three isolation and treatment centres were established; and 12 metric tons of personal protective equipment, several Ebola kits, and one glove tent were provided to strengthen case management and diagnostic capacity.

On March 21, Tanzania also reported its first-ever case of Marburg. Following reports of cases and deaths in the Kagera region, the outbreak was confirmed through laboratory analysis conducted by the health authorities. The national SURGE team,

which had been jointly trained by WHO and Africa CDC, was deployed to the affected region along with five WHO technical officers to carry out further epidemiological investigations, monitor contacts, and provide clinical care. With support from WHO and other partners, the Ministry of Health scaled up the response effort to prevent the further spread of the disease. As of March 30, a total of eight cases and five deaths had been reported, and the outbreak was confined to two districts.



\$500,000
in funding
provided



03
Isolation and
treatment centres
established



899 metric tons
medical supplies
dispatched during
January and March



30 mobile teams
20 mobile health
and nutrition teams
deployed to Tigray, and
10 more to Amhara

Humanitarian crises in northern Ethiopia

Humanitarian assistance access in northern Ethiopia improved significantly following the signing of a ceasefire between armed groups and the government in November 2022. High rates of malnutrition in drought-affected areas were compounded by inadequate access to health services and water, sanitation, and hygiene infrastructure, posing major public health risks. WHO AFRO delivered critical supplies to local health facilities, with 899 metric tons of medical supplies dispatched between January and March. Twenty mobile health and nutrition teams were deployed to Tigray and ten more to Amhara. As access improves further while the needs of the population continue to increase, WHO and other partners will need to scale up their response efforts and launch new activities to support the recovery of the health system.

Tropical Cyclones

The first quarter of each year coincides with the cyclone season in southern Africa. On average, 13 cyclone events with wind speeds exceeding 63 km per hour form in the southwest Indian Ocean each year. In 2023, two major tropical cyclones caused mass disruptions and loss of life in southern Africa. On January 19, Cyclone Cheneso made landfall in Madagascar's Sava region.

The storm affected 18 regions and 49 districts, directly impacting 91,960 people. At least 36 people died and more than 52,275 were displaced due to the cyclone, which also damaged 66 healthcare facilities. Between February and March, a second storm, Cyclone Freddy, battered multiple countries in southern Africa. Cyclone Freddy was an exceptionally protracted and deadly event that lasted for over five weeks and caused over 500 deaths. The cyclone passed over Madagascar twice, but Malawi was hit the hardest, as incessant rains caused catastrophic flash floods, especially in and around Blantyre. The damage to Mozambique was compounded by a rare second landfall, which resulted in additional flooding and wind damage.



03
Public health
experts deployed



\$1.867m
provided to four
countries to strengthen
field operations



91,960
people affected in
18 regions and 49
districts



13
cyclone events in six
countries

WHO established a Regional Cyclone Command Centre in Nairobi and deployed three public health experts to coordinate disaster preparedness and response activities in Madagascar, Malawi, Mauritius, Mozambique, Seychelles, and Zimbabwe. In collaboration with partners, EMTs were deployed in Blantyre, Phalombe, and Zomba. Eleven experts were also deployed: five to Malawi, three to the Cyclone Command Centre, and three to Mozambique. In Malawi, WHO supported the deployment of 37 surge staff to deliver emergency care in Blantyre, Mulanje, and Phalombe districts. To strengthen field operations, an additional US\$535,000 in funding was provided to Madagascar, US\$720,000 to Mozambique, and US\$612,000 to Malawi. Emergency health kits and tents were also provided to restore access to essential medicines and support the establishment of temporary health posts.



Annexure: Cyclone Cheneso and Freddy Key figures



People affected

3,913,804



Deaths

918



**Internally displaced
people**

985,123



**Houses flooded/
damaged**

1,202,817



**Health care facilities
flooded/damaged**

305



**Schools flooded/
damaged**

4139



World Health
Organization